January 27, 2016

Mr. David Seltz
Executive Director
Health Policy Commission
50 Milk St., 8th floor
Boston, MA 02109

Submitted electronically

Subject: Proposed Accountable Care Organization (ACO) Certification Standards

Dear Mr. Seltz,

I am submitting this letter on behalf of Fenway Health in response to the Request for Public Comment on Proposed Accountable Care Organization (ACO) Certification Standards. Fenway Health is a community health center located in Boston that serves everyone regardless of their ability to pay. We have a special focus on those who are lesbian, gay, bisexual and transgender and are the largest provider of HIV services in New England. We are a member of BIDCO, a value based physician and hospital network, established in 2013. BIDCO was an early adopter of merging global budget accountability with the delivery of high-quality care and is currently a Pioneer ACO. We appreciate the opportunity to provide input on this important topic.

We are supportive of the Health Policy Commission's (HPC) goal of promoting continued care delivery transformation, and are therefore supportive of setting standards for minimum criteria for the structure and functions of ACOs. However, we are concerned that certain aspects of the proposed criteria are overly prescriptive and may limit innovation and/or be overly burdensome to ACOs, whatever their size and structure, on becoming certified. Below are specific suggestions on how the HPC may consider adjusting the criteria outlined in its communication to address concerns that affect all ACOs in their ability to participate in the ACO certification process, and thereby also potentially affect their ability to participate in future state programs, such as the MassHealth payment reform program. From our perspective, these suggestions will assist in the HPC's ability to remain flexible in this changing environment.

Mandatory vs. Reporting Only Criteria

Criterion #4 - The ACO governance structure provides for meaningful participation of primary care, addiction, mental health (including outpatient), and specialist providers.

Having an ACO governance structure that includes meaningful participation from an array of providers reflective of the population it serves is critically important to us. However, the criterion, as written, is overly prescriptive. ACOs vary greatly geographically and operationally. It is more appropriate for the governance structure to provide meaningful participation from a

representative group of providers rather than to explicitly require meaningful participation from any subset of providers. Additionally, assessing the phrase "meaningful participation" is broad and its assessment is highly subjective. As written, it could be challenging for applicant ACOs to understand what is truly required to meet the guidelines put forth. We recommend this criterion either be moved to a reporting-only criterion or be modified in a manner that permits enough flexibility such that each ACO be allowed a governance structure that represents its providers. Additionally, we recommend that the HPC align its governance requirements with those established for federal ACO programs, so entities that participate in federal ACO programs are able to satisfy the state ACO criteria as well.

Criterion #7 - The ACO has approaches for risk stratification of its patient population based on criteria including, at minimum:

- *Behavioral health conditions*
- *High cost/high utilization*
- *Number and type of chronic conditions*
- *Social determinants of health (SDH)*

The approach also may include:

- *Functional status, activities of daily living (ADLs), instrumental activities of daily living (IADLs)*
- *Health literacy*

We agree that risk stratification capabilities are an important factor for the HPC to consider in certifying ACOs. However, the HPC should not require ACOs to include approaches for risk stratification for social determinants of health at this time. While it is valuable for ACOs to understand how to use social determinants of health as factors in risk stratification, it is a developing practice. Additionally, there are no industry standards regarding the format and collection of this type of data, and there are operational barriers to making it a prerequisite for ACO certification. Though we use socioeconomic and other demographic information to address social determinants of health outside of risk stratification, payers typically do not provide the data necessary to include social determinants of health in risk stratification, and this information is not consistently gathered in Electronic Health Records (EHRs) in a manner that would make it usable for this purpose. Also, once standards are set for the collection and format of this information, it will take significant resources to develop and implement a risk stratification strategy which includes social determinants of health. We are eager to work with the Commonwealth and payers on standards for how to collect and use this type of information, but there must first be an opportunity to capitalize on pending efforts to establish sound and reliable risk stratification tools that include social determinants of health prior to requiring its inclusion in the criteria. Therefore, we recommend that this aspect of the criterion be changed to reporting only until such time that there is a recognized industry standard that ACOs may implement.

We also note that some payers do not typically provide the data necessary to fully document behavioral health conditions. For example, some payers exclude substance abuse claims or all

behavioral health related claims from the files they send to provider organizations; therefore, certain behavioral health conditions are not incorporated into risk stratification approaches. We recommend that the HPC take these factors into consideration as it determines the documentation requirement necessary to meet ACO certification thresholds.

Criterion #9 – ACO demonstrates and assesses effectiveness of ongoing collaborations with and referrals to:

- *Hospitals*
- *Specialists*
- *Post-acute care providers (i.e., SNFs, LTACs)*
- *Behavioral health providers (both mental health and substance use disorders)*
- *Long-term services and supports (LTSS) providers (i.e., home health, adult day health, PCA, etc.)*
- *Community/social service organizations (i.e., food pantry, transportation, shelters, schools, etc.)*

We agree that it is important for ACOs to work with a variety of provider types/community resources, but this criterion is overly prescriptive and sets unrealistic expectations. Depending on the populations served by the ACO, it may be more beneficial for an ACO to collaborate with long-term services and supports providers or social service organizations, while other ACOs may appropriately focus on post-acute providers and specialists. ACOs have to make difficult decisions about where to focus resources, and building and evaluating relationships with providers and community organizations takes time. Requiring ACOs to demonstrate ongoing collaborations with an overly broad and prescriptive list of provider/organization types may not reflect best practice as it could push ACOs to focus on too many areas at one time and dilute the impact of those efforts. Additionally, as noted in our response to Criterion #4, as currently written this criterion can only be evaluated subjectively by both the ACO and the HPC as to what is sufficient to meet the standard. As such, we suggest that the HPC more clearly define what is sufficient to meet the standard, and that it be moved to reporting only. Modifying this criterion to require collaboration with two or three of these types of providers is more likely to result in meaningful collaborations, is more attainable for ACOs, reduces the reporting burden, and still emphasizes the importance of these relationships.

Criterion #11—The ACO participates in budget-based contract for Medicaid patients by the end of Certification Year 2 (2017).

While it may be reasonable for a payer to require HPC certification, it is not reasonable for the HPC to require participation in contracts with Medicaid or any specific payer. If the intent of the HPC's ACO certification is to be multi-payer then it is inappropriate to single out Medicaid in this manner. While we understand the Commonwealth's interest in encouraging participation in alternative payment models, including those for Medicaid patients, this criterion could limit providers' ability to negotiate fair contracts or put ACOs in a position of either accepting terms of an agreement, or losing its ACO certification. Also, some ACOs may not have a substantial number of Medicaid patients in order to enter into a budget-based contract for that population.

Criterion #13 – ACO regularly performs cost, utilization and quality analyses, including regular trending and forecasting of performance against budget and quality measure targets, and works with practices and providers within the ACO to meet goals and targets. Analysis could be completed by a vendor or in-house.

ACO disseminates reports to providers, in aggregate and at the practice level, and makes practice-level results on quality performance available to all participating providers within the ACO.

Financial and quality forecasting and internal reporting can be very helpful tools for ACOs to achieve success. However, designing and producing provider or practice level reports is a resource-intensive task, whether accomplished internally or through a third-party vendor. For small and/or nascent ACOs it will likely be very difficult to meet this standard. Additionally, it is possible that results seen at a practice level do not pass the actuarial reasonableness test, and therefore reporting out at this level is not the most effective management tool. We recommend adjusting this criterion to initially only require this type of tracking at the ACO level, which would allow smaller ACOs the ability to meet the criterion.

Criterion #15 – ACO describes steps it is taking to advance or invest in the population health of one or more communities where it has at least 100 enrollees through a collaborative, integrative, multi-organization approach that acknowledges and accounts for the social determinants of health.

As noted in response to Criterion #9, ACOs have limited resources and have to be judicious about where they focus their efforts. Explicitly requiring ACOs to invest in programs that are often less likely to have a short-term impact on the budgets to which ACOs are managing under payer contracts may be too aggressive at this time. We appreciate the HPC's interest in promoting population health in local communities, but we recommend moving this requirement to reporting only.

Criterion #24 – The ACO demonstrates a process for identifying preferred providers, with specific emphasis to increase use of providers in the patient's community, as appropriate, specifically for:
– oncology
– orthopedics
– pediatrics
– obstetrics

We find this criterion, as worded, to be overly prescriptive. This criterion is appropriate as reporting only, but the specific provider types should not be identified. Additionally, the requirement to provide documentation of provider communication should be removed. Instead, the HPC should ask ACOs to provide evidence that a preferred provider relationship exists, such as a narrative description of how it approaches the identification of preferred providers.

Criterion #31-- The ACO assesses the needs and preferences of its patient population with regard to race, ethnicity, gender identity, sexual preference, language, culture, literacy, social needs (food, transportation, housing, etc.) and other characteristics and develops plan(s) to meet those needs. This includes provision of interpretation/translation services and materials printed in languages representing the patient population (5% rule).

We are supportive of this criterion as a reporting-only standard. Understanding the needs and preferences of a patient population with regard to these characteristics is very important but, as noted in our response to Criterion #7, this type of data on all patients is not easily accessible. Therefore, we support the HPC's categorization of this measure as reporting only. We also recommend using the term "sexual orientation" instead of "sexual preference." The former is a more widely used term to describe sexuality. It is used, for example, in the final Stage 3 Meaningful Use rule from the Office of the National Coordinator of Health Information Technology issued October 6, 2015.[1] To many gay, lesbian and bisexual people "sexual orientation" is preferable to "sexual preference," which sounds outdated.

Opportunities to Reduce Reporting Burden

The current set of proposed standards will require a significant amount time and effort from organizations wishing to be certified as ACOs. We understand that the HPC wants to collect a robust set of data on ACOs; however, there are ways to accomplish that with less administrative burden. Specifically, we suggest the following changes to reduce reporting burden:

Criterion #2 – We appreciate that the HPC has indicated it will coordinate with the RPO process to the extent possible and would like to emphasize how important that is to reducing unnecessary administrative burden. Producing provider lists for different payers and for the RPO process is already a resource-intensive process for many ACOs, and we appreciate efforts to align file formats and definitions.

Criterion #3 – Because ACOs currently participating in Medicare ACOs are required to have a patient/consumer advocate representation on their board, we recommend that the HPC accept participation in the Medicare Shared Savings Program, Pioneer ACO Model, or Next Generation ACO Model as sufficient evidence of meeting this requirement, and remove the narrative requirement for this criterion for those ACOs.

Criterion #8 – Rather than requiring a written description of all qualifying programs, we recommend that the HPC require ACOs to describe one to three of their programs.

[1] Department of Health and Human Services, Office of the Secretary. 45 CFR Part 170, RIN 0991-AB93. 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Based Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications. Released October 6, 2015. Available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-25597.pdf. Accessed October 7, 2015

Criterion #29 – In developing specifications for this criterion, we recommend that the HPC keep in mind that many IPA-like ACOs may not have access to billing information for their participating providers. Defining this criterion in such a way that does not require applicant ACOs to report on billing information they may not have, will greatly reduce reporting burden.

Protecting Proprietary Information

We strongly support the HPC's stated intent to not release ACO application materials without the expressed consent of the ACO. The information requested under the proposed criteria contains proprietary information about the ACO's strategy and business arrangements. We are especially concerned about the possibility of the information collected in response to criteria 7, 13, 20, and 30 becoming public. Exempting this information from public disclosure laws is critical to ensuring equitable competition in the marketplace.

Thank you again for this opportunity to comment on this important program. Fenway Health will continue to engage with its colleagues in the government of the Commonwealth to find innovative ways to manage cost and improve quality of care. Please contact me with any questions.

Sincerely,

Stephen L. Boswell, MD, FACP
Assistant Professor of Medicine
Harvard Medical School

President & CEO
Fenway Health

cc: Dr. Stuart Altman, Dr. Carole Allen